

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47

CERTIFICATE OF DEATH

Reg. Dist. No. 01807 195

1. PLACE OF DEATH:

County Howard Co.City or town near Laurel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne ArundelCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charlotte Mariotte Cokley

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

W. N. Cokley

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Jan 1, 1863

8. AGE:

Years 82Months 6Days 11

If less than one day

hrs. _____

min. _____

9. Birthplace

Portland, A. D. Co. Md.

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

Home

FATHER

12. Name

James A. Jacobs

13. Birthplace

A. D. Co. Md.

MOTHER

14. Maiden name

Margaret Whaley

15. Birthplace

A. D. Co. Md.

16. Informant

Archibald B. Cokley

Address

Laurel, Md.

17. (Burial, cremation, or removal, Which?)

BurialDate thereof Feb 15, 1945

Cemetery or crematory

Trinity Cemetery

Location

Ann Arbor, Michigan

18. Funeral director

Laurel, Md.

Address

2151 45

19. (Date rec'd by registrar)

2/15/45

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 19 45 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 8 19 45 to Feb 12 19 45and that I last saw him alive on Feb 12 19 45Immediate cause of death Pneumonia DURATION 4 daysgeneralizedarteriosclerosis 2 1/2 yrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

J. M. Warren MD

M. D. or other

Address Laurel Date signed 2/15/45

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

01808

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HowardCity or town Ellichaester
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 72

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellichaester
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Louise Lough

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Wm Franklin Lough

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 23, 19128. AGE: Years 72 Months 8 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Ellichaester, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Phillip Moore13. Birthplace Ellichaester, Md.14. Maiden name Eliza Ann Grace15. Birthplace Ellichaester, Md.16. Informant Mr. LoughAddress Ellichaester, Md.17. Burial Date thereof Feb. 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation Ellichaester, Md.18. Funeral director Easton SonsAddress Ellicott City, Md.19. Feb 22 19 45 John B. Lughan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1945 at 8:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 8 19 44 to Feb - 20 19 45and that I last saw her alive on Feb - 15 19 45Immediate cause of death Adeno-Carcinoma UterusDURATION 1.75

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations N.D.

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide N.D. Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. Lloyd JohnsonAddress Ellicott City, Md. M. D. or other _____Date signed 2-22-45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

01809

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
City or town Ellicott City Small
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. St Johns Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Curry
4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

8. (b) Name of husband or wife Wm L Curry

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1871

8. AGE: Years 74 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Pa
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name P. Bayer

13. Birthplace Pa

MOTHER 14. Maiden name Danielia Carl

15. Birthplace Pa.

16. Informant Mrs. Annie Finckham

Address Ellicott City Md

17. Burial Date thereof 2-27-45
(Burial, cremation, or removal. Whole?) (month) (day) (year)

Cemetery or crematory Good Shepherd Cem

Location Rockland Howard Co Md

18. Funeral director J.C. Higginbotham

Address Ellicott City Md

19. 2-27 1945 John B. Longham
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945 at 8 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 24 1945 and that I last saw him alive on Feb 24 1945

Immediate cause of death

Metastatic carcinoma
of adenocarcinoma

Due to Primary origin: Carcinoma of ascending colon, Caecum

Due to

Other conditions Patient had a femoral hernia

(Include pregnancy within 3 months of death)

Major findings of operations Repair of femoral hernia

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John B. Longham M. D. or other

Address Ellicott City Md Date signed 2/28/45

CERTIFICATE OF DEATH

RECORDED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

01810 / 91

Reg. Dist. No. 191

I. PLACE OF DEATH:

County HowardCity or town Danels
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Danels
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Laura Clematis Davis

3. (b) Social Security Number

none4. Sex F 5. Color or race W 6. (a) Single; married, widowed, or divorced Widow6. (b) Name of husband or wife Zachariah Davis7. Birth date of deceased (mo., day, yr.) Feb. 17, 1864 6. (c) If alive, give age _____ years8. AGE: Years 80 Months 11 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Martinsburg W.Va
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Unknown13. Birthplace "14. Maiden name Ellen Sweeney Jones15. Birthplace W.Va.16. Informant Mrs. Norman MullinsAddress Danels, Md.17. Burial Date thereof 2-8-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good ShepherdLocation Ellen City, Md.18. Funeral director F.C. Hig. undertakerAddress Ellen City, Md.19. 2-6 19 45 Jhu B. Lughan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1945 at 9³⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-5 19 45 to 2-5 19 45and that I last saw h. ER alive on no date 19 _____Immediate cause of death Hypertensive Cardio-Vascular DiseaseDURATION 1 year

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George S. Buehler M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or otherAddress Ellen City, Md. Date signed 2-5-45

RELEASED TO THE STATE DEPARTMENT

RECEIVED BY THE STATE DEPARTMENT

RECEIVED

MAR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 01811 193

1. PLACE OF DEATH:

County.....*Howard*
City or town.....*Daisy*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Rachael A. Holland

3. (b) Social Security Number

4. Sex.....*F* 5. Color of race.....*C* 6.(a) Single, married, widowed, or divorced.....*married*6.(b) Name of husband or wife.....*Charles Holland*7. Birth date of deceased (mo., day, yr.).....*Jan. 31 1913* 6.(c) If alive, give age.....*37* years8. AGE: Years.....*32* Months..... Days.....*22* If less than one day..... hrs. min.9. Birthplace.....*Howard Co*
(Town, county, and state)10. Usual occupation.....*Home work*

11. Industry or business.....

FATHER 12. Name.....*Walter Powell*
13. Birthplace.....*Howard Co.*MOTHER 14. Maiden name.....*Hattie Frazier*15. Birthplace.....*Montgomery Co.*16. Informant.....*Charles Holland*Address.....*Woodbine Md.*17. *Burial* Date thereof.....*Feb 25, 1945*
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory.....*Daisy*Location.....*Daisy Howard Co.*18. Funeral director.....*H. M. Snyder*Address.....*Mt. Airy Md.*19. *2/28/45* 20. *45* Registrar.....*C. Pearlman*
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Feb. 22 45*, at.....*11:30 PM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*December 19 44* to.....*Feb 22 19 45*
and that I last saw him.....*Feb 21*.....*19 45*Immediate cause of death.....*Uremia* DURATION.....*1 wk*Due to.....*Chronic Nephritis* ?

Due to.....

Other conditions.....*Chr. Hypertension* ?

(Include pregnancy within 3 months of death)

Major findings of operations.....*none* Date of op.....Autopsy results.....*none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Walter Grall* M. D. or otherAddress.....*Mt. Airy Md* Date signed.....*2/22/45*

UNITED STATES DEPARTMENT OF JUSTICE

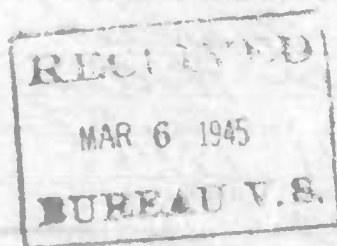
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01812

Reg. Dist. No.

195

1. PLACE OF DEATH:

County Howard
 City or town High Ridge Land R. F. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 mo 23 days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Howard
 City or town High Ridge R. F. D. Land
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Lettie Hoskins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Joseph Hoskins

7. Birth date of

deceased (mo., day, yr.)

Aug 18, 1888

8. AGE:

56

Years

5

Months

18

Days

If less than one day

hrs.

min.

9. Birthplace

Powersville N. C.
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Queen Victoria Freeman

15. Birthplace

Powersville N. C.

16. Informant

Calvin E. Hoskins

Address

High Ridge Howard Co Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Feb 8 1945
(month) (day) (year)

Cemetery or crematory

Calvert

Location

Norfolk Va

18. Funeral director

Ridgely Selby

Address

404 Wash are Land Md

19. (Date rec'd by registrar)

2 16 45

19

Frank Shipley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 19 45, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-519 45

to

2-519 45and that I last saw h. PR alive onno date

Immediate cause of death

Hypertensive Cardio-Vascular Disease

DURATION

10 years

Due to

Cerebral HemorrhageInstant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Burdett MD
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY, D. or other

Address

Elliot City Md

Date signed

2-5-45

RECEIVED
FEB 19 1945
BUREAU 4 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01813

Reg. Dist. No.

1. PLACE OF DEATH:

County HowardCity or town near Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ellen M. Jenkins

3. (b) Social Security Number

120115

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

John A. Jenkins

7. Birth date of deceased (mo., day, yr.)

1863

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

82

hrs.

min.

9. Birthplace

MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 21 19 75 A. W. Hedrick
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

WW

MEDICAL CERTIFICATION

20. DATE OF DEATH

2 - 18

19

45 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-18

19

45

to

2-18

19

45

and that I last saw him alive on

no date

19

Immediate cause of death

Arteriosclerotic Cardiac -
Vascular Disease

DURATION

1 year

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

George E. Burdette M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

M. D. or other

Address

Ellicott City, Md

Date signed

2-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

01814

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH: Howard.
 County Near Wishon
 City or town Wishon
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Near Wishon
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Woodbine
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Viola A. Knill

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced MARRIED.
 6. (b) Name of husband or wife W. Keefer Knill
 7. Birth date of deceased (mo., day, yr.) Nov. 21, 1884 6. (c) If alive, give age 59 years
 8. AGE: Years 60 Months 3 Days 5 If less than one day
 hrs. min.

9. Birthplace Baltimore City Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business
 12. Name Caleb Hackett
 13. Birthplace MARYLAND.
 14. Maiden name Emma C. Grindler
 15. Birthplace MARYLAND.
 16. Informant Mr. W. Keefer Knill
 Address Woodbine Md.

17. Burial Burial Date thereof 2-28-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woudon Park
 Location Baltimore City, Md.
 18. Funeral director C.M. Walz
 Address Winfield Md.

19. 2-27- 19 45 E. Paul Martin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb'y 26 19 45 at 1:25 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June, 1944 19 45 to Feb. 26 19 45
 and that I last saw her alive on Feb. 24, 19 45

Immediate cause of death Metastasis to rt lung DURATION 7 Mo.
 Due to Carcenoma of left Breast 10 yrs
 Due to
 Other conditions Carcenoma of liver 1 mo.

(Include pregnancy within 3 months of death)
 Major findings of operations Carcenoma of left Breast Date of op. 1934
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) (County) (State)
 Means of Injury Injured at work?

23. SIGNATURE Stanley Grubill M. D. or other
 Address Chesapeake, Md. Date signed 2/26/45

RE.

MAR 6 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

01815

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Howard
 City or town Savage
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 39 Baltimore St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Cassie E. Marsh

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife James R. Marsh

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1884

8. AGE: Years Months Days It less than one day
about 80 ? ? hrs. min.9. Birthplace Keyser W. Va.
(Town, county, and state)

10. Usual occupation House hold duties

11. Industry or business

12. Name James Davis

13. Birthplace Morgantown W. Va.

14. Maiden name Katherine Massey

15. Birthplace Balto. Md.

16. Informant Mrs. Clara Marsh

Address 34, 37 Kenyon Ave Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10, 1945
(month) (day) (year)

Cemetery or crematory Cedar Hill

Location Annapolis Road

18. Funeral director Eastern Sons

Address 6 Ellicott City, Md.

2/9/45. Frank Shipley

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945 at 69 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27, 1945 to Feb 7, 1945

and that I last saw her alive on Feb. 6, 1945

Immediate cause of death Coronary thrombosis - Instant

Due to Hypertension +

Due to Atherosclerosis 3 yrs.

Other conditions

(include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley M.D. or other

Address Savage, Md.

Date signed 2/8/45

RECEIVED
MAR 5 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01816 195

Reg. Dist. No.

1. PLACE OF DEATH:

County HowardCity or town Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 104 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md. County HowardCity or town Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. County Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William Kenneth Phelps

3. (b) Social Security Number

4. Sex M.5. Color of skin Wh.6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Dora Phelps7. Birth date of deceased (mo., day, yr.) May 21, 18748. AGE: Years 70 Months 8 Days 28

If less than one day

.....hrs.min.

9. Birthplace Savage, Md.

(Town, county, and state)

10. Usual occupation Catholic Church member11. Industry or business Wid. Mary Ward12. Name John H. Phelps13. Birthplace Ind.14. Maiden name Eliza W. Groff15. Birthplace Howard Co. Md.16. Informant Robert A. PhelpsAddress Savage, Md.17. Burial Date thereof Feb 20, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Savage, Md.Location Savage, Md.18. Funeral director Frank ShipleyAddress Savage, Md.19. 2/19/45 (Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 18 1945 at 1:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18 1945 to Feb. 18 1945and that I last saw him alive on Feb. 17 1945Immediate cause of death Coronary Thrombosis

DURATION

Due to Hypertension 1 yr.Due to Chr. Myocarditis 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ✓

.....Date of op.

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22-VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.Address Savage, Md. Date signed 2/19/45

RECEIVED

MAR 6 1945

BUREAU V.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

01817

Reg. Dist. No. 24 195

1. PLACE OF DEATH:

County HowardCity or town Woodstock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Woodstock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Martha Ellen Howard

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Edwin Howard

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Sept. 2, 1857

8. AGE:

Years

Months

Days

If less than one day

87510

hrs.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Stewart Eugene George

13. Birthplace

MD

MOTHER

14. Maiden name

Henrietta Mitchell

15. Birthplace

MD

16. Informant

Ruth G. Hammond

Address

Woodstock, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 14, 1945
(month) (day) (year)

Cemetery or crematory

London Park Cemetery

Location

Baltimore, Md.

18. Funeral director

C. Harry Eves

Address

Hykesville, Md.

19.

(Date rec'd by registrar)

Feb. 13, 1945C. Harry Eves

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 12, 1945at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Feb. 1, 1945to Feb. 12, 1945and that I last saw her alive on Feb. 11, 1945

Immediate cause of death

Intestinal obstructionpartialDue to probable malignancyintestine

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Dr. E. Martin

M. D. or other

Address

PandalltownDate signed 2/12/45

260.
275
295
325

RECEIVED
FEB 19 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

01818

Reg. Dist. No.

195

1. PLACE OF DEATH:

County HowardCity or town Lund med Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

Whiskey Bottom Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HowardCity or town Lund med. R.F.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No. Whiskey Bottom Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ella Wilson Southard

3. (b) Social Security Number

4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Wm T. Southard

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May-14-18718. AGE: Years 73 Months 9 Days 12 If less than one day

hrs. min.

9. Birthplace Wash. D.C.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm H. Wilson13. Birthplace Dist of Columbia14. Maiden name unknown15. Birthplace Wm T. Southard16. Informant Wm T. SouthardAddress 900-10th N.W. Wash D.C.17. Burial Date thereof 2-26-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory 1400 Chapin St. N.W.Location Washington D.C.18. Funeral director W.W. Chambers CoAddress 1400 Chapin St. N.W. Wash. D.C.19. 2/26/45 Frank Shipley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-26-45 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28-45 to Feb. 26-45and that I last saw him/her alive on Feb. 26-45Immediate cause of death Pelvic CarcinomatousCarcinoma of UterusDue to 1 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ✓Antopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Frank Shipley, M.D.Address Savage, Md. Date signed 2/26/45

RECEIVED
MAR 6 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01819

Reg. Diat. No.

239195

1. PLACE OF DEATH:

County HowardCity or town Near Laurel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Near Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George W. Stausfield

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowedB. (b) Name of husband or wife Julie N.7. Birth date of deceased (mo., day, yr.) November 19, 1858

6. (c) If alive, give age _____ years

8. AGE: Years 86 Months 2 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Thomas Stausfield13. Birthplace MD.14. Maiden name Mary Verney15. Birthplace MD.16. Informant Thomas W. StausfieldAddress Laurel Md.17. Burial Date thereof Feb 12-45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory MA ViewLocation Sykesville Md.18. Funeral director Lloyd HauserAddress Laurel Md.19. February 2, 1945 Coa E. Wachtler
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 19 1945 at 17:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 - 19 45 to Feb 8 19 45and that I last saw him alive on Feb 7 19 45

Immediate cause of death

Chr Intake of hypoxia
myocardial infarction

DURATION

7.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. B. SpencerM. D. W. B. SpencerAddress Laurel Md. Date signed Feb 12, 1945

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01820

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
 City or town Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 67 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

George A. Neal
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Isabell Neal
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 26, 1877
 8. AGE: Years 67 Months 6 Days 26 If less than one day _____ hrs. _____ min.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21, 1945, at 10 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-21, 1945, to 2-21, 1945
 and that I last saw him alive on no date, 19____
 Immediate cause of death Hypertensive Cardis-Vascular Disease
 DURATION 9 year.
 Due to _____
 Due to _____
 Other conditions Cerebral hemorrhage
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

9. Birthplace Ellicott City, Md.
 (Town, county, and state)
 10. Usual occupation Rail Grinder
 11. Industry or business Balto. Transit
 12. Name Emanuel Neal
 13. Birthplace Maryland
 14. Maiden name Alicia Dupont
 15. Birthplace Maryland
 16. Informant Mrs. Charles A. Neal
 Address Ellicott City, Md.
 17. Burial Date thereof Feb. 24, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Good Shepherd
 Location Rockland, Md.
 18. Funeral director Easton Bros
 Address Ellicott City, Md.
 19. Feb. 22, 1945 John B. Lughnan
 (Data rec'd by registrar) Registrar

Signature George E. Burdette M.D.
 DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other
 Address Ellicott City, Md. Date signed 2-28-45

RECEIVED

MAR 6 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore 752

CERTIFICATE OF DEATH

Reg. Dist. No. 01822 192

1. PLACE OF DEATH:

County NorwardCity or town West Friendship
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County NorwardCity or town West Friendship
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Arthur Thompson

3. (b) Social Security Number

none

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed or divorced

married

6. (b) Name of husband or wife

Catherine Thompson

B. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

July 9, 1869

8. AGE:

Years

Months

Days

If less than one day

75714

hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

—

FATHER

12. Name

Thos J. Thompson

13. Birthplace

md

MOTHER

14. Maiden name

Minerva Wales

15. Birthplace

md

16. Informant

Arthur Thompson Jr.

Address

West Friendship

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Feb 26 1945

Cemetery or crematory

Providence

Location

Blindly md

18. Funeral director

F.C. Higginbotham

Address

Ellicott City md

19. Date rec'd by registrar

Feb 26 1945

Date

1945Alice J. Hobb

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945 at 9:15 N

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 19 45 to Feb 23 1945

and that I last saw him alive on

Immediate cause of death

Arteriosclerotic cardiovascular
heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Ellicott City md Date signed Feb 26 1945

RECEIVED
MAR 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

01821

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Howard
 City or town Hutton (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 55 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Howard
 City or town Hutton (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Benj. Howard Thompson

3. (b) Social Security Number

—

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.

8. (b) Name of husband Mary E. Thompson

8. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Oct 19, 1867

8. AGE: Years 77 Months 3 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Edmon, Howard Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business General products

12. Name Andrew Jackson Thompson

13. Birthplace Maryland, Md.

14. Maiden name Mary Elizabeth Hardisty

15. Birthplace Highland, Howard Co. Md.

16. Informant M. Paul Thompson

Address Hutton Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 7, 1945
 (month) (day) (year)

Cemetery or crematory St. Louis Cemetery

Location Clarksville, Howard Co. Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Feb. 5, 19 45 Gertrude R. Lawler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 45 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 4 19 45
 and that I last saw him alive on Feb 3 19 45

Immediate cause of death Chronic myocarditis DURATION 5 yrs

Due to Hypertension DURATION 8 yrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert J. McNamee Jr. M.D. or other _____
Laurel Ing Date signed 2/4/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01823

Reg. Dist. No.

1. PLACE OF DEATH:

County Howard Co.City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Hanover
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MARY GEBELEIN WINTERS

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Henry S. Winters6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 27, 18538. AGE: Years Months Days If less than one day
91 10 8 hrs. min.9. Birthplace Pikesville, Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name John Gebelain13. Birthplace Germany14. Maiden name Barbara Koerner15. Birthplace Md.16. Informant Miss Anna C. WintersAddress Hanover, Md.17. Burial Date thereof Feb. 7, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2/6/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 45 at 12:05 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 45 to Feb 5 19 45 and that I last saw him alive on Feb 4 19 45

Immediate cause of death

Myocardial infarction

DURATION

18 daysDue to Chronic MyocarditisDue to arteriosclerosisOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Tickner M. D. or otherAddress 1609 Main St Date signed 2/3/45